BEFORE THE VIRGINIA BOARD OF MEDICINE

IN RE: CHRISTOPHER GEORGE MARSHALL, M.D.
License Number: 0101-247529
Case Number: 208840

ORDER OF SUMMARY SUSPENSION

Pursuant to Virginia Code § 54.1-2408.1(A), a quorum of the Board of Medicine ("Board") met on October 14, 2021. The purpose of the meeting was to receive and act upon information indicating that Christopher George Marshall, M.D., may have violated certain laws and regulations relating to the practice of medicine in the Commonwealth of Virginia, as more fully set forth in the "Notice of Formal Administrative Hearing and Statement of Allegations," which is attached hereto and incorporated by reference herein.

WHEREUPON, pursuant to its authority under Virginia Code § 54.1-2408.1(A), the Board concludes that a substantial danger to public health or safety warrants this action and ORDERS that the license of Christopher George Marshall, M.D., to practice medicine in the Commonwealth of Virginia is SUSPENDED. It is further ORDERED that a hearing be convened within a reasonable time of the date of entry of this Order to receive and act upon evidence in this matter.

Pursuant to Virginia Code § 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection or copying on request.

FOR THE BOARD

Jennifer L. Deschene

For William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED:
10/14/2021

STATEMENT OF ALLEGATIONS

The Board alleges that:

1. At all times relevant hereto, Christopher George Marshall, M.D., was licensed to practice medicine in the Commonwealth of Virginia.

2. Dr. Marshall violated Virginia Code § 54.1-2915(A)(3), (12), (13), (16), (18), and (19) and 18 VAC 85-20-29(A)(3) of the Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic ("Board's Regulations"), in that between approximately 2014 and October 2020, during the course of the practitioner/patient relationship, he engaged in conduct of a sexual nature with Patient A (a 23-year-old female at the initiation of the relationship) that a reasonable patient would consider lewd and offensive and exploited the practitioner/patient relationship for his own sexual gratification. Specifically:

a. In or about December 2013, after meeting each other during a concert at a local Richmond fetish club/bar, Dr. Marshall, a family care physician at a Midlothian, Virginia practice, and Patient A began a romantic/sexual relationship, which continued over the course of approximately the next seven years (through approximately October 2020). Between approximately 2015 and 2017, Dr. Marshall and Patient A cohabited at Dr. Marshall's residence.

b. Between approximately 2014 and October 2020, while engaged in a sexual and/or romantic relationship with Patient A, Dr. Marshall evaluated, assessed, and/or treated Patient A for Ehlers-Danlos disease; ADHD; depression; anxiety; recurrent, chronic pyelonephritis; herpes virus; yeast infections; nausea; smoking cessation; suture removal; and skin/tissue lesions/growths (detailed below); including prescribing and dispensing to the patient multiple controlled substances.

c. On multiple occasions, Dr. Marshall sexualized his medical care and treatment of Patient A, which he provided in/under unsafe and/or unsanitary conditions, and/or utilized medical equipment and/or controlled substances and/or alcohol during sexual acts with the patient:

i. In or about 2014, Dr. Marshall, while ungloved and without adequate and/or appropriate sterilization, performed two surgical procedures on and a gynecological examination of Patient A in his residence. As seen on video recordings, while Patient A was lying prone, fully undressed (naked), with her arms and legs bound by ligatures (ropes) on his bed, Dr. Marshall, while partially clothed and/or naked:

- On one occasion, he surgically removed a mole/skin lesion from Patient A's forearm and sutured the wound. By his own admission, prior to initiating the surgery, Dr. Marshall numbed the area by injecting lidocaine with epinephrine (both C-VI medications, which he obtained from his practice), into the patient's arm. During the procedure, Dr. Marshall showed Patient A how to place an interrupted suture and "how to do an instrument tie." After initiating the fourth and final suture, Dr. Marshall untied Patient A's wrists and allowed the patient to pull the suture through and attempt to tie it. (Patient A was not a licensed medical practitioner in Virginia authorized to perform such procedures). Patient A informed the Department of Health Professions' ("DHP") investigator that prior to performing the surgical procedure, Dr. Marshall dispensed Xanax (alprazolam, C-IV), Ambien (zolpidem tartrate, C-IV) and/or a muscle relaxant to her, and remarked that the surgery would be "hot."

- On a second occasion, after placing his mouth on Patient A's clitoris and/or labia, he surgically removed a "skin tag" from what he identified as the patient's "clitoral hood." By his own admission during his April 15, 2021 interview ("interview") with the DHP investigator, Dr. Marshall numbed Patient A's genitalia with "a couple of drops of lidocaine with epinephrine…using an insulin syringe." (Lidocaine and epinephrine are both C-VI medications). Dr. Marshall stated that he had

administered a dosage each of Ambien and Xanax to Patient A, remarking, "You probably won't remember most of this, which is probably a good thing." Just prior to the procedure, Dr. Marshall further stated, "Ok baby, I'm ready to start ruling your bits," and "I love your bits, baby." After grasping Patient A's labia/clitoris with his bare hand, Dr. Marshall wiped the patient's right eye with his fingers when she complained of an itch. At the conclusion of the procedure, Dr. Marshall commented, "Perfect bits." Patient A informed the DHP investigator during her February 4, 2021 interview that at the conclusion of the procedure, Dr. Marshall applied a substance that she opined was colloidal silver. Dr. Marshall confirmed with the DHP investigator during his interview that Patient A fell unconscious following this surgical procedure.

- On a third occasion, he performed a gynecological examination of Patient A. Using a lighted speculum he obtained from his previous practice in New York, Dr. Marshall grasped Patient A's nipples/breasts (bound by ropes, as was her neck), pulling each breast upward, one at a time, and moved the speculum back and forth horizontally, prior to releasing the breast/nipple from the speculum. Dr. Marshall applied a lubricant to the speculum with his bare finger, and stated, "Mmm, yummy" and "I really do like your vagina. It's beautiful." Dr. Marshall inserted the speculum into the patient's vagina, narrating the examination, rubbing Patient A's breast and stating, "I can see all of your insides." At the conclusion of the examination, Patient A asked, "How do I look, doc?" Dr. Marshall replied, "You look good." Patient A asked for Dr. Marshall's "medical opinion." Dr. Marshall replied, "Very nice."

ii. Patient A informed the DHP investigator, in February 10 and April 3, 2021 emails and during her January 18, 2021 interview, that in or about December 2019, Dr. Marshall, while at his residence, applied/administered lidocaine and utilized materials obtained from his practice to remove sutures from her thigh (previously placed during a surgical procedure at a Tucson, Arizona hospital).

Patient A stated that after the suture removal, Dr. Marshall and she engaged in sexual relations.

iii. Patient A stated that Dr. Marshall supplied her with viscous lidocaine, which he obtained from his practice, for application in/around the patient's vaginal area during sexual acts/intercourse.

iv. Patient A stated that Dr. Marshall engaged in sexual acts/intercourse with her while she was consuming alcohol and sedated with controlled substances (e.g. Ambien and/or tizanidine) he prescribed and/or dispensed to her.

v. As seen in a video recording, Dr. Marshall engaged in sexual acts/intercourse with Patient A while inflating a blood pressure cuff fitted around her neck.

d. As seen in multiple video recordings/photographs dating from approximately 2014 to 2015, Dr. Marshall engaged in sexual acts/intercourse with Patient A during which:

- Patient A's arms, legs, neck, and/or breasts were bound with ropes/zip ties, and/or her mouth was gagged and/or she was blindfolded. At times, Patient A's ankles were bound to a wooden pole, board, or PVC pipe, with her legs spread apart.
- Dr. Marshall grasped Patient A's neck with his hand(s), tightening his grip. At times, the patient's face reddened.
- Dr. Marshall pulled on a strap and/or rope wrapped around Patient A's neck. On at least two occasions, Patient A complained that she could not breathe. On one occasion, Dr. Marshall replied, "If you can scream, you can breathe." Photographs indicate that on at least one occasion, the strap(s)/rope(s) left red marks and a bruise on Patient A's neck.
- Dr. Marshall pressed his forearm against Patient A's throat.
- Dr. Marshall struck Patient A about the buttocks, back, feet and neck with an object while her limbs were bound, leaving red marks on her skin.
- Dr. Marshall, while standing, placed Patient A in a chokehold and dragged her, and lifted her feet off the ground with his elbow and forearm wrapped around her neck.
- Dr. Marshall pulled Patient A's hair, pinched her nipple, slapped her face and torso, and put/pressed his fist(s) on her back or into her abdomen.

3. Dr. Marshall violated Virginia Code § § 54.1-2915(A)(1), (12), (16), (17), and (18), 54.1-3303 and 54.1-3408(A) and 18 VAC 85-20-26(C) of the Board's Regulations, in that he prescribed Patient A a controlled substance without a legitimate medical purpose, as indicated by the following:

a. Prescription records show that on July 15, 2015, Dr. Marshall prescribed Patient A #30 zolpidem tartrate 10mg/30 days with five refills. Prescription records further show that on September 23, 2015, Dr. Marshall prescribed Patient A #30 Ambien 10mg/30 days with five refills, approximately three months prior to when the prior prescription (with refills) would have run out if taken as prescribed. Prescription records indicate that Patient A filled the July 15th prescription on July 18, 2015 and filled/refilled the September 23rd prescription on September 26 and November 10, 2015. Patient A's Virginia Prescription Monitoring Program ("PMP") record shows that she filled additional prescriptions written by Dr. Marshall for #30 Ambien/30 days on January 12, 2016 (written on January 6, 2016) and April 28, 2016 (written on April 26, 2016).

b. Dr. Marshall failed to document the Ambien prescriptions in his medical chart for Patient A.

c. During his interview, Dr. Marshall initially denied the Ambien prescribing, stating, "I never prescribed narcotics or sedatives to her. I can tell you that with absolute certainty." Dr. Marshall further stated, "I couldn't tell you why she would need Ambien. She would sleep all day, sleep all night." On further inquiry from the DHP investigator, when shown a portion of Patient A's PMP report indicating the Ambien prescriptions he wrote, Dr. Marshall stated that he did not recall writing the prescriptions, but stated that he must have done so to alleviate the patient's anxiety-induced insomnia, medical information he also failed to document in his medical chart.

d. As detailed above, Dr. Marshall dispensed/administered Ambien and Xanax to Patient A prior to the surgical genitalia procedure described in Paragraph 2(c)(i). By his own admission

during his interview, Dr. Marshall did not prescribe Patient A benzodiazepines. Further, during his interview, Dr. Marshall stated that "many" of the medications Patient A took "may have been prescribed to me," and that he "occasionally smoked pot with" the patient.

e. Despite the fact that Dr. Marshall reported to the DHP investigator during his interview that, "I never had sex with her when she was snowed," additional video(s) show Dr. Marshall recording Patient A "passing out" after ingesting Ambien, and show Dr. Marshall initiating sexual intercourse with Patient A while she appeared to be asleep/unconscious.

4. Dr. Marshall violated Virginia Code § § 54.1-2915(A)(12), (16), (17), and (18), 54.1-3303 and 54.1-3408(A) in that, between approximately 2014 and 2018, he prescribed controlled substances to individuals with whom he was personally acquainted outside of a bona fide practitioner/patient relationship. Specifically:

a. On at least two occasions (April 12, 2015 and August 11, 2018), Dr. Marshall prescribed Individual 1, Patient A's minor relative, amoxicillin (C-VI). On or about August 8, 2018, Dr. Marshall obtained viscous lidocaine from his practice, dispensed it to Patient A, and instructed her to administer the lidocaine to Individual 1 to alleviate pain from recurrent mouth sores. Dr. Marshall failed to document examinations, assessments or diagnoses for Individual 1, or the amoxicillin prescriptions or dispensation of lidocaine associated with these incidents.

b. Prior to Patient E (Patient B's male friend) presenting to Dr. Marshall to establish a physician/patient relationship on March 30, 2016 (at the age of 35) at his practice, Dr. Marshall prescribed the individual #30 Ambien 10mg/30 days with four refills on January 3, 2015. Individual E's PMP report shows that this prescription was filled/refilled on January 3, February 10, April 23, May 30 and July 1, 2015. During his July 20, 2021 interview with the DHP investigator, Patient E stated that he recalled Dr. Marshall prescribing him Ambien on one occasion, but did not recall any refills.

c. Prior to Patient F (Dr. Marshall's female friend/acquaintance, with whom he attended "various venues and events") presenting to Dr. Marshall to establish a physician/patient relationship on April 28, 2015 (at the age of 32) at his practice, Dr. Marshall prescribed the individual Adderall (dextroamphetamine-amphetamine, C-II) in varying dosages and Xanax, as indicated in the chart below:

Date Written	Date Filled	Medication and Dosage
2/8/14	2/10/14	#30 dextroamphetamine-amphetamine ER 20mg/30 days
1/17/14	2/13/14	#60 alprazolam 0.25mg/30 days
2/26/14	2/26/14	#90 dextroamphetamine-amphetamine 10mg/30 days
5/28/14	5/28/14	#90 dextroamphetamine-amphetamine 10mg/30 days
6/6/14	1/17/14	#60 alprazolam 0.25mg/30 days
7/28/14	7/30/14	#90 dextroamphetamine-amphetamine 20mg/30 days
8/28/14	10/27/14	#90 dextroamphetamine-amphetamine 20mg/30 days
12/20/14	1/3/15	#30 alprazolam 0.25mg/8 days

d. Prior to Patient B (Dr. Marshall's male friend and former neighbor, with whom Dr. Marshall stated he attended Dragon Con in Atlanta, Georgia a few times) presenting to Dr. Marshall to establish a physician/patient relationship at his practice on May 30, 2014 (at the age of 33), Dr. Marshall prescribed the individual #30 phentermine (C-IV) 15mg/30 days on January 31, 2014, with five refills. Individual B's PMP report indicates that he filled/refilled this prescription on February 5, March 1, April 7, and May 8, 2014. Patient B obtained additional refills from this prescription on June 2 and July 15, 2014, after his initial office visit with Dr. Marshall.

5. Dr. Marshall violated Virginia Code § 54.1-2915(A)(3), (13), (16) and (18) and 18 VAC 85-20-26(C) of the Board's Regulations in his care and treatment of Patients A - G between approximately 2012 and 2020. Specifically:

a. Regarding Patient A:

i. Between approximately July 2015 and October 2020, Dr. Marshall prescribed and/or dispensed to Patient A multiple medications without documenting corresponding assessments, examinations, and/or diagnoses for which these medications were prescribed/dispensed:

- Dr. Marshall's medical chart indicates that between December 2015 and November 2019, he prescribed Patient A multiple medications/refills, to include Chantix, Diflucan, sertraline (Zoloft), Bactrim DS, valacyclovir (Valtrex), albuterol inhalers, citalopram hydrobromide (Celexa), escitalopram oxalate (Lexapro), and ondansetron HCl (Zofran) (all C-VI medications), absent further information or medical explanation.

- Patient A's prescription information indicates that between July 2015 and January 2020, she filled/refilled additional prescriptions written by Dr. Marshall for multiple medications, which Dr. Marshall failed to document in his medical chart, as follows:

  - #60 tizanidine (Zanaflex, C-VI)) 4mg/20 days (7/15/15, 4/28/16)
  - #60 dextroamphetamine-amphetamine 10mg/30 days (12/30/15)
  - #30 zolpidem tartrate/30 days (7/18/15, 9/26/15, 11/10/15, 1/12/16, 4/28/16)
  - #60 meclizine (C-VI) 25mg/20 days (1/3/16)
  - #30 sertraline 25mg/30 days (1/12/16)
  - mupirocin (C-VI) ointment (C-VI, 5/10/16)
  - #30 promethazine 25mg Q 6 hours (on or about 11/17/16) (2 refills)
  - #30 amitriptyline (C-VI) HCl 25mg (on or about 6/26/18) (4 refills)
  - #30 ondansetron ODT 8mg/30 days (9/14/18)
  - #1 Diflucan (fluconazole, C-VI) 150mg (12/27/18)
  - #20 Ketorolac (C-VI) 10mg Q 6 hours (6/7/19)
  - #28 Bactrim DS (C-VI) 800-160mg/14 days (1 refill) (9/13/19)
  - # 30 ondansetron HCl 8mg/15 days (5 refills) 10/7/19
  - #56 Chantix 1mg/23 days (4 refills) (10/17/19)
  - #21 methylprednisolone 4mg (C-VI) (1/14/20)

- Between 2014 and 2019, Dr. Marshall dispensed to Patient A numerous C-VI prescription medication samples obtained from his practice, such as granisetron HCl 1mg (prescribed for chemotherapy or radiation-induced nausea/vomiting), ondansetron 4mg and 8mg, Bupap (butalbital/acetaminophen) 50mg - 300mg, Pennsaid (diclofenac sodium 40mg) and Uribel, without

including a written order for the medications in his medical chart, noting in the chart that the medications were dispensed, providing to the patient administration instructions and information about potential side effects, or documenting the dose provided to the patient, all in violation of acceptable standards of medical practice and his practice's drug sample dispensing policy. Dr. Marshall removed the samples from his practice without following established practice procedures, which required him to sign out the samples and enter specific information in the sample medication dispensing log, such as the patient's name, the dispensing date, his name as the dispensing physician, the medication name/strength, lot number, manufacturer, quantity dispensed, and usage directions.

- Between 2017 and 2018, Dr. Marshall dispensed to Patient A unused dosages of butalbital-acetaminophen-caffeine (Fioricet, C-VI) 50-325-40mg prescribed for Patient H and Patient I, as detailed in Paragraph 7(a).

ii. Dr. Marshall failed to adequately and appropriately treat Patient A for depression and anxiety. As described above in Paragraph 5(a)(i), Dr. Marshall prescribed Patient A sertraline and amitriptyline, absent a mental health assessment or evaluation. Further, in or about the spring of 2017, Patient A experienced a mental health crisis during which she stayed in the shower at a friend's home for approximately three days. The friend called Dr. Marshall for help and he assisted Patient A. Subsequently, Dr. Marshall failed to refer Patient A for a mental health assessment/evaluation/treatment.

iii. By his own admission to the DHP investigator during his interview, in or about 2014, Dr. Marshall failed to document the surgical removal of the mole/skin lesion from Patient A's arm or the surgical removal of the "skin tag"/lesion from the patient's genitalia. By his own admission to the DHP investigator, Dr. Marshall failed to order/send the excised lesions for biopsy/laboratory analysis. Patient A stated during her March 1, 2021 interviews with the DHP investigator that following the procedure, Dr. Marshall kept the "skin tag" in a jar.

iv. On several occasions, Dr. Marshall assessed Patient A's physical/mental health, but failed to include copies of the corresponding documentation, discussed below, in his medical chart:

- By letter dated November 25, 2019, Dr. Marshall addressed a judge/disability claim reviewer, supporting Patient A's claim for disability benefits. In the letter, Dr. Marshall described the patient's physical and mental limitations, causally linking them to Ehlers-Danlos syndrome ("a progressive musculoskeletal disorder"), ADD "that further impairs her ability to focus, and stay on task despite medical management of this condition," and generalized anxiety disorder "with frequent flare-ups and attacks," which he signed, "Christopher G. Marshall, MD, MBA." Dr. Marshall initially informed the DHP investigator that he did not remember writing the November 25, 2019 disability letter for Patient A. After the DHP investigator showed him the letter, Dr. Marshall acknowledged writing it.

- Dr. Marshall wrote a note dated July 6, 2020 on his practice prescription pad, defining physical limitations on Patient A's work capacity, stating, "Patient suffers from a musculoskeletal connective tissue disorder that necessitates her lifting no more than 20 pounds, and should be allowed to sit or lean when not actively involved in other activities."

- Dr. Marshall wrote a note dated July 13, 2020 on his practice prescription pad excusing Patient A from "work duties" from that date through July 17, 2020, "due to back injury…Injury date: 7/12/2020."

b. Regarding Patient B (formerly Individual B, as detailed in Paragraph 4(d)), whom Dr. Marshall treated between May 2014 and March 2019 for diagnoses of hypothyroidism, irritable bowel syndrome, low testosterone, depression, hyperlipidemia, gastroesophageal reflux disease (GERD), and asthma/allergies:

i. Dr. Marshall failed to adequately assess, evaluate and treat Patient B for mental health conditions. At Patient B's initial office visit on May 30, 2014, Dr. Marshall documented his prior history of depression, for which he noted the patient was prescribed Wellbutrin (bupropion, C-VI) XL 300mg (Dr. Marshall also noted prior prescriptions for Seroquel, Topamax, Prozac and Lexapro, all C-VI medications). Approximately six and one-half weeks later, on July 15, 2014, Dr. Marshall authorized four #30 Wellbutrin XR 300mg "refill[s]" for Patient B,[1] authorizing four additional monthly refills of this medication on November 24, 2014. Approximately one week later, on December 1, 2014, absent an office visit or recorded explanation, Dr. Marshall prescribed Patient B #30 Fetzima (an SNRI, C-VI) ER 40mg/30 days with 11 refills. On September 29, 2016, absent an office visit, Dr. Marshall prescribed Patient B #60 diazepam (Valium, C-IV) 10mg/30 days (one refill), without documenting a medical justification for this medication. In the same manner, Dr. Marshall prescribed Patient B lamotrigine (Lamictal, C-VI) between November 2018 and March 2020, as indicated in the chart below. There is no indication in Dr. Marshall's medical chart that at any time during the treatment period, he assessed/evaluated Patient B's mental health or that he contacted, consulted or requested treatment records from the patient's prior treating physician/mental health provider.

ii. Dr. Marshall failed to follow up on referrals to specialists:

- On January 26, 2015, Dr. Marshall referred Patient B to a gastroenterologist for "recurrent nausea." There is no indication that Dr. Marshall consulted or contacted the gastroenterologist at any time during the treatment period.
- On July 30, 2015, absent an office visit, Dr. Marshall referred Patient B to a pulmonary disease specialist for "asthma/possible OSA [obstructive sleep apnea]," absent further explanation/documentation. There is no indication that Dr. Marshall consulted or contacted this pulmonary specialist at any time during the treatment period, despite the fact that Dr. Marshall continued to prescribe

[1]Faxed documents from Patient B's pharmacy to Dr. Marshall, dated 7/15/14 and included in Dr. Marshall's medical chart for Patient B, indicate that Dr. Marshall/staff crossed out the former treating physician's name and contact information on the pharmacy refill request, writing in Dr. Marshall's information instead.

Patient B medications such as albuterol and Breo Ellipta (both C-VI medications) inhalers.

- On August 10, 2015, absent an office visit, Dr. Marshall referred Patient B to "endocrinology" for "low testosterone/hypothyroidism," absent further explanation or documentation. There is no indication that Dr. Marshall followed up with "endocrinology" at any time during the treatment period, despite the fact that Dr. Marshall continued to prescribe Patient B Synthroid (C-VI) through approximately December 2018 and phentermine (C-IV, as detailed below) through approximately May 2017.

iii. On multiple occasions without an office visit or absent medical justification, Dr. Marshall prescribed Patient B controlled substances, as indicated in the chart below:

Date	Medication and Dosage
12/11/14	Medrol Dosepak (C-VI) 4mg
12/11/15	Ciprodex (C-VI) suspension
1/20/16	#14 amoxicillin (C-VI) 500mg/7 days
1/21/16	Medrol Dosepak 4mg (1 refill) #45 Tessalon Perles (benzonatate, C-VI) 100mg/15 days (3 refills)
8/26/16	#30 tizanidine HCl 4mg/10 days (2 refills)
9/21/16	#30 Zofran ODT 8mg/10 days (3 refills)
9/29/16	#60 diazepam 10mg/30 days (1 refill)
8/30/17	#60 Belviq (C-IV) 10mg/30 days (3 refills)
5/11/18	#90 lamotrigine 150mg/90 days (one refill)
10/31/18	Medrol Dosepak 4mg
11/12/18	Z-pack (azithromycin, C-VI)/5 days
11/20/18	#90 lamotrigine 150 mg/90 days (1 refill)
3/19/19	#90 lamotrigine 150mg/30 days (1 refill)
3/31/20	#90 lamotrigine 150mg/90 days (1 refill) #180 buspirone (BuSpar) HCl (C-VI) 15mg/90 days (1 refill) Seroquel 25mg Breo Ellipta (C-VI) aerosol powder (5 refills)

Dr. Marshall's medical chart indicates that Patient B's last office visit was on November 13, 2016 (no office visits between 11/13/16 and 3/19/19).

iv. On August 7, 2017, absent an office visit, Dr. Marshall prescribed Patient B #90 Fioricet 50-300-40mg/15 days (1 refill), a Medrol Dosepak (2 refills), and #60 Percocet (C-II) 10-

325mg/15 days, based solely on the patient's report that he had a "recent wisdom teeth extraction and is having a difficult recovery with ongoing [pain and headache]."

c. Regarding Patient C (a male personal acquaintance whom Dr. Marshall met through Patient D), whom Dr. Marshall treated between March 2012 (at age 44) and June 2016[2]:

i. Prior to initiating treatment, Dr. Marshall failed to obtain an adequate medical or medication history or prior treatment records for Patient C.

ii. Dr. Marshall failed to adequately or appropriately assess, evaluate, or treat Patient C for mental health conditions. Specifically, Dr. Marshall's medical chart for Patient C includes one progress note, for an office visit on March 7, 2012. At this (initial) visit, Dr. Marshall documented the patient's complaints of fatigue and concentration difficulties, and that he felt "wound-up" inside without relief from Xanax or Ambien. Patient C reported that he had not slept in three days, was experiencing altered sensation in his ten fingers and ten toes, and that he experienced similar sensations ten years prior, while concomitantly taking Xanax, Zoloft and Ambien, also without significant relief. Dr. Marshall assessed Patient C with anxiety and fatigue, ordered laboratory blood tests to include a CBC with differential/platelet, comprehensive metabolic and lipid panels, TSH and free and total LC/MS testosterone and prescribed the patient #20 valacyclovir HCl 500mg/10 days (with three refills).

iii. Dr. Marshall continued to treat Patient C through June 2016 by prescribing multiple controlled substances, absent any corresponding office visits or laboratory tests, and without documenting medical justification. Dr. Marshall routinely failed to document many of the prescriptions in his medical chart for Patient C, as shown below:

Date	Medication/Quantity/Dosage/Days' Supply	Refills	Rx indicated in
5/21/12	#60 Xanax 1mg/20 days	2	Dr. Marshall's medical chart

[2]Respondent initially denied, during his April 15, 2021 interview with the Investigator, that he treated Patient C.

6/4/12	#30 Adderall XR (24H) 20mg/30 days	N/A	Dr. Marshall's medical chart
8/31/12	#30 zolpidem tartrate 10mg/30 days #90 Xanax 1mg/30 days	6 6	pharmacy records
1/8/13	#120 Percocet 10-650mg/30 days		pharmacy records
2/6/13	#10 valacyclovir HCl 1000mg/10 days #60 Cipro 500mg/30 days #90 amoxicillin 500mg/30 days #60 doxycycline hyclate 100mg/30 days	3 2 2 2	Dr. Marshall's medical chart
3/7/13	Cortisporin (C-VI) otic suspension	1	pharmacy records
5/2/13	#60 Xanax 1mg/20 days	3	Dr. Marshall's medical chart
6/12/13	#60 Xanax 1mg/20 days clobetasol proprionate (C-VI) 0.05% ointment	3 4	pharmacy records
9/6/13	#30 Zoloft 50mg/30 days	11	Dr. Marshall's medical chart
9/8/13	#30 Valtrex 1gm/30 days	5	pharmacy records
9/9/13	#30 Wellbutrin XL, ER 150mg/30 days	5	Dr. Marshall's medical chart
10/1/13	#90 Xanax 1mg/30 days #30 zolpidem tartrate /30 days	3 4	pharmacy records
1/4/14	#30 zolpidem tartrate 10mg/30 days	4	pharmacy records
1/26/14	#1 Medrol Dosepak #1 albuterol MDI	 3	pharmacy records
2/10/14	#1 Flonase suspension/30 days	4	pharmacy records
2/14/14	#60 Xanax 1mg/20 days	3	Dr. Marshall's medical chart
3/10/14	#30 bupropion (Wellbutrin) XL 150mg/30 days	N/A	pharmacy records
3/31/14	#30 zolpidem tartrate 10mg/30 days	3	Dr. Marshall's medical chart
6/10/14	#90 Xanax 1mg/30 days	3	Dr. Marshall's medical chart
8/18/14	Flonase suspension/30 days	5	Dr. Marshall's medical chart
9/3/14	#30 Percocet (C-II) 10mg-325mg/30 days	N/A	Dr. Marshall's medical chart
11/10/14	clobetasol propionate cream, 0.05%/30 days	4	Dr. Marshall's medical chart
3/16/15	#60 Xanax 1mg/30 days	1	Dr. Marshall's medical chart
10/26/14	Androgel 1.62% pump/30 days	11	Dr. Marshall's medical chart
12/8/15	#30 Tessalon Perles 100mg/10 days #1 Z-pak (azithromycin)/5 days	1 N/A	pharmacy records pharmacy records

12/30/15	#1 Medrol Dosepak	N/A	pharmacy records
6/17/16	#10 valacyclovir 1000mg/10 days	4	Dr. Marshall's medical chart

iv. Dr. Marshall failed to assess/evaluate Patient C for ADD/ADHD or to obtain prior treatment records indicating an ADD/ADHD diagnosis, prior to prescribing the patient Adderall XR on June 4, 2012 (as shown in the chart above).

v. In his May 4, 2021 written statement provided to the DHP investigator, Dr. Marshall stated that in 2016, he "cut off" his prescribing to Patient C as he "began to suspect him of abuse." Yet, there is no indication that Dr. Marshall referred Patient C for substance abuse assessment, evaluation, counseling and/or treatment, nor is a patient dismissal letter included in Dr. Marshall's medical chart.

d. Regarding Patient D, a 47-year-old male (Dr. Marshall's friend, whom he met in a "prepper" group via "Meetup.com," a social media, shared-interest-group site) and whom Dr. Marshall treated between June 4, 2015 and March 18, 2021 for acute, left-sided low back pain:

i. Prior to treating Patient D, Dr. Marshall failed to obtain an adequate medical or medication history (initial visit 6/4/15).

ii. Dr. Marshall's October 30, 2017 progress note indicates that he saw Patient D for a "questionable kidney infection," absent any further information.

iii. Dr. Marshall failed to include in his medical chart lumbar spine and chest x-rays/results he ordered at Patient D's March 1, 2018 office visit.

iv. Dr. Marshall failed to adequately treat Patient D for a mental health condition(s) in that on or about March 7, 2018, without documenting a mental health evaluation, assessment or diagnosis, Dr. Marshall prescribed Patient D #60 Wellbutrin ER 150mg/30 days (3 refills).

v. Dr. Marshall prescribed Patient D controlled substances without an office visit or medical justification, as follows:

- #30 amoxicillin 500mg/10 days (8/2/18)
- #6 sildenafil citrate (Viagra, C-VI), 100mg/30 days (8/20/18, 5 refills)
- Medrol Dosepak 4mg, Z-pak (azithromycin, C-VI)/5 days, #90 benzonatate 200mg/30 days (11/2/18)

vi. Dr. Marshall initiated opioid therapy for Patient D and prescribed other controlled substances in the absence of diagnostic evidence to warrant the prescribing:

- On May 15, 2020, Dr. Marshall prescribed Patient D a Medrol Dosepak 4mg, #30 tizanidine HCl 4mg/10 days, and #28 Percocet (C-II) 5-325mg/7 days without obtaining, reviewing, or documenting diagnostic imaging/results, or performing/documenting a musculoskeletal exam. Rather, Dr. Marshall documented, "consistant [sic] pain, has had x rays in the last couple yrs., has seing [sic] chiropractor in the past…some right sciatica, takes 2 aleve in the am with mixed results - being active helps."

- Approximately three months later (August 17, 2020 office visit), absent a documented physical examination or assessment, Dr. Marshall prescribed Patient D #30 Percocet 5-325mg and #45 tizanidine HCl 4mg/15 days (1 refill) for "Acute left-sided low back pain without sciatica."

- At Patient D's November 3, 2020 office visit, Dr. Marshall "refill[ed]" the patient's tizanidine (1 refill) and Percocet and at the patient's request, referred him to a pain management specialist.

e. Regarding Patient E (formerly Individual E, as detailed above in Paragraph 4(b)), who identified himself as Dr. Marshall's friend during his July 20, 2021 interview with the DHP investigator, and whom Dr. Marshall treated from March to September 2016:

i. Dr. Marshall's medical chart includes incomplete progress notes dated March 30 and April 12, 2016, indicating Patient E's complaints of cholesterol issues and joint pain, with no recorded medical history, physical examination, or adequate or appropriate, additional treatment information. The progress notes are unsigned and bear the notations, "…not verified…Pending…"

ii. In his next progress note dated May 4, 2016, Dr. Marshall indicated a "Well male exam," noting that the patient was "traveling to Peru and needs vaccines." Dr. Marshall documented a "Travel advice encounter," a prescription for #20 acetazolamide (C-VI) 125mg BID/20 days and the administration of a TDAP Boostrix immunization. Despite the fact that Dr. Marshall documented ordering laboratory ("lab") testing, there are no lab results in his medical chart, and Patient E confirmed during his interview that the patient was supposed to get blood work afterward, but never did.

iii. Dr. Marshall's next and final medical chart entry is a September 30, 2016 "Telephone Encounter," stating "Start Hepatitis A Vaccine Suspension…1 dose(s)," with no further documentation.

iv. Patient E informed the DHP investigator during his interview that he is currently Dr. Marshall's patient, and that Dr. Marshall treated him at his practice for a dog bite wound (unspecified date), at which time Dr. Marshall prescribed him an antibiotic. Dr. Marshall failed to document this visit or any additional/subsequent visits in his medical chart.

f. Regarding Patient F (formerly Individual F as detailed above in Paragraph 4(c)), whom Dr. Marshall treated between April 28, 2015[3] and March 2020 for diagnoses of ADHD, PMDD (premenstrual dysphoric disorder), irregular menstruation, anxiety, and recurrent, major depressive disorder:

[3]Respondent's medical chart shows that he ordered laboratory testing for Patient F prior to her initial appointment (on or about April 13 or April 23, 2015).

i. Dr. Marshall failed to adequately/appropriately assess, evaluate, and/or treat Patient F for anxiety and depression. Specifically:

- At Patient F's initial visit on April 28, 2015, despite noting "Psychology: Negative for anxiety, depression, irritability," Dr. Marshall diagnosed the patient with "PMDD" and "Anxiety," absent additional information. Dr. Marshall prescribed Patient F Xanax 0.25 mg daily, noting that the patient was prescribed Zoloft 100mg/day. Approximately one month later (May 27, 2015), Dr. Marshall prescribed Patient F #90 Zoloft 100mg/90 days, in response to a pharmacy refill request, and continued to prescribe this medication through August 2017.

- More than two years later, at Patient F's August 11, 2017 office visit, Dr. Marshall documented a depression diagnosis, noting, "Gets severe PMDD and anxiety. States has been going back and forth between multiple SSRI's because they stopped working." On this date, Dr. Marshall, noting that Patient F had self-titrated her Zoloft dosage to 200mg/day (from the 100mg/day prescribed by Dr. Marshall), discontinued Zoloft and began prescribing the patient venlafaxine (Effexor, C-VI).

- At Patient F's next office visit on or about September 29, 2017, Dr. Marshall indicated that she was there to "have some paperwork filled out." Dr. Marshall failed to include a copy of this "paperwork" in his medical chart.[4] Further, Dr. Marshall indicated, "Pt is still not ok her anxiety she is always on the edge and she is still very stressed and she doesn't feel any better…dosen't [sic] want to get out of bed, depressed, and her voice is going." Dr. Marshall further documented, "Pt with ongoing severe anxiety/depression related to chemical imbalances/history of abuse and emotionally difficult job (works with grieving family members)." Based on this information, Dr. Marshall renewed Patient F's venlafaxine, Xanax and Adderall and referred her to a psychiatrist. Despite the fact that Dr. Marshall

[4] On or about May 1, 2018, Respondent completed additional disability "forms" for Patient F but failed again to include copies of the forms in his medical chart.

continued to treat Patient F through approximately March 2020[5], there is no indication that Dr. Marshall followed up on the psychiatric referral, or contacted/consulted the psychiatrist to ensure that the medications he continued to prescribe (Adderall, Xanax, Lexapro, Wellbutrin and/or Prozac[6]) comported with the psychiatrist's treatment plan.

- At her October 19, 2017 office visit, Patient F informed Dr. Marshall that she was unable to "take her regular meds," which aggravated her underlying depression and anxiety, because she was six weeks pregnant. Patient F further indicated that she was "out of work on FMLA following a nervous breakdown," and that she had her "meds adjusted." Dr. Marshall noted Patient F's request to extend her FMLA leave through October 27, 2017, due to a scheduled pregnancy termination (October 25, 2017). Dr. Marshall failed to contact, consult, or obtain treatment records from the practitioner who "adjusted" Patient F's "meds," and failed to include a copy of the patient's FMLA documentation in his medical chart.

ii. Dr. Marshall failed to adequately/appropriately assess/evaluate/treat Patient F for ADHD. At Patient F's initial April 28, 2015 office visit, Dr. Marshall noted, "ADHD" and "Start Adderall,"[7] prescribed Adderall 20mg/day, and continued to prescribe Adderall throughout the treatment period. Prior to initiating this prescribing Dr. Marshall failed to obtain the patient's prior treatment records indicating an ADD/ADHD diagnosis, and otherwise failed to assess or evaluate Patient F for ADD/ADHD.

iii. Dr. Marshall failed to adequately/appropriately assess, evaluate, and/or treat Patient F for substance abuse. Specifically, on or about October 18, 2017, absent a corresponding office

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[5] In or about April 2018, Patient F relocated to Florida.
[6] For example, on or about October 18, 2017, Respondent prescribed Patient F Prozac 40mgy/day with five refills, without an office visit or medical justification.
[7] As detailed above in Paragraph 4(c), Dr. Marshall previously prescribed Patient F (Individual F) Adderall absent a bona fide practitioner/patient relationship.

visit, Dr. Marshall prescribed Patient F #30 naltrexone HCl (C-VI, prescribed for alcohol and/or opioid substance abuse) with five refills, absent medical justification. Dr. Marshall's medical chart does not include a substance abuse evaluation/assessment, and despite the fact that Dr. Marshall prescribed Patient F addictive medications such as Adderall and Xanax during the treatment period, there is no indication that he appropriately employed monitoring methods such as reviewing the patient's PMP report, counting pills, and/or ordering/conducting urine drug screens to ensure the patient's medication compliance.

iv. On or about January 3, 2018, Dr. Marshall prescribed Patient F #10 Cipro (C-VI)/5 days, absent an office visit and without documenting any further information.

g. Regarding Patient G (whom Dr. Marshall stated he met through "Meetup.com," with whom Dr. Marshall "often" goes camping), whom Dr. Marshall diagnosed/treated between January 2012 (at age 49) and November 2019 for hyperlipidemia, left shoulder, knee and ankle pain, neck pain, "[a]nxiety panic attacks," PTSD, recurrent upper respiratory infections, and irritable bowel syndrome:

i. On multiple occasions without performing an appropriate evaluation or assessment, or ordering or obtaining diagnostic imaging, Dr. Marshall prescribed Patient G controlled substances for pain relief:

- At Patient G's August 14, 2012 office visit, Dr. Marshall prescribed #30 meloxicam 15mg/day with six refills and #60 acetaminophen-codeine #3/300mg-30mg (Tylenol #3, C-III) QID prn with three refills, based on Patient G's complaints of "Joint pain knees and elbows," noting right knee surgery in the early 1990s and that the patient's last x-ray was "quite awhile ago." Dr. Marshall failed to document a physical examination or assessment of Patient G's knee or elbow.

- Absent a corresponding office visit or medical indication, Dr. Marshall documented a prescription for a Medrol 4mg Dosepak on November 15, 2012 and a prescription for #60 Tylenol #3/15 days on July 12, 2016.

- At Patient G's January 25, 2018 office visit, without documenting a musculoskeletal exam, Dr. Marshall noted "back muscle spasm" and prescribed a Medrol 4mg Dosepak, #30 tizanidine HCl 4mg/10 days, and #30 tramadol HCl (C-IV) 50mg/7 days, based on the patient's subjective pain complaints of "sharp pain" on a scale of 4-5/10.

- Patient G's PMP report shows that on March 26, 2017, he filled a prescription written by Dr. Marshall for #40 hydrocodone-acetaminophen/7.5mg-300mg (Vicodin, C-II)/10 days. Dr. Marshall failed to document the prescription or a corresponding evaluation/assessment in his medical chart.

ii. Dr. Marshall failed to adequately or appropriately consult or coordinate Patient G's care and treatment with other treatment providers:

- At Patient G's April 4, 2017 office visit, Dr. Marshall referred the patient for physical therapy due to left knee trauma from a reported motorcycle accident 10 days prior (on or about March 25, 2017). There is no indication that Dr. Marshall requested or obtained Patient G's physical therapy records, or that he contacted the patient's physical therapist regarding care and treatment.

- Regarding Patient G's gastrointestinal ("GI") complaints/treatment:

  - On November 6, 2012, Dr. Marshall telephonically prescribed Patient G #60 mesalamine (C-VI) - 1000mg suppositories/30 days (with three refills), absent a corresponding office visit or medical indication. Three days later (November 9, 2012), Dr. Marshall diagnosed Patient G with "GI bleed" pursuant to a "telephone encounter," without documenting any additional information. Dr. Marshall noted that he ordered laboratory diagnostic testing, to include a CBC with differential, CMP, ferritin and serum labs. By letter dated November 12, 2012, Dr. Marshall informed Patient G that the lab results were normal.

o On January 9, 2018, Dr. Marshall referred Patient G to a gastroenterologist for a colonoscopy/colon cancer screening. Dr. Marshall's medical chart does not include a colonoscopy/colon cancer screening report. Approximately sixteen days later, on January 25, 2018, Patient G complained of GI symptoms to include abdominal pain, cramping, bloating and alternating diarrhea and constipation. Dr. Marshall diagnosed irritable bowel disease and opined that the patient's "[s]ignificant stress in life" might be aggravating his symptoms.

o At Patient G's April 5, 2019 office visit, Dr. Marshall noted complaints of a one-day history of left, lower quadrant tenderness, diarrhea, fatigue, chills, and loose, bloody/mucus stools, indicating, "has h/o diverticular disease," without additional information, and prescribed #12 tramadol HCl 50mg/3 days.

Dr. Marshall's medical chart does not indicate that at any time during the treatment period, he referred Patient G to or contacted/consulted an appropriate specialist to adequately/appropriately diagnose and treat the patient's persistent GI symptoms/complaints.

iii. Dr. Marshall failed to adequately or appropriately assess, evaluate, or treat Patient G's mental health condition(s). Specifically, at Patient G's April 15, 2016 office visit, Dr. Marshall diagnosed anxiety and PTSD, noting that the patient was experiencing generalized and excessive anxiety and "panic disorder panic attacks" due to three deaths in the family, "getting a troop ready for deployment" and his wife's breast cancer diagnosis. Dr. Marshall prescribed #30 sertraline HCl 50mg/30 days and #60 buspirone HCl 10mg/30 days, each with five refills, and referred Patient G to a mental health practitioner. There is no indication that Dr. Marshall requested or obtained psychiatric treatment records from this practitioner for inclusion in his medical chart, or otherwise coordinated care and treatment. Further, despite the fact that Dr. Marshall's January 24, 2019 Progress Note indicates that Patient G reported

"[f]eeling down, depressed or hopeless…[n]early every day," Dr. Marshall failed to address the patient's mental health at this visit.

5. Dr. Marshall violated Virginia Code §§ 54.1-2915(A)(3), (13), (16), (17), and the Board's Regulations Governing the Prescribing of Opioids and Buprenorphine (effective March 15, 2017) (Board's Prescribing Regulations) in his care and treatment of Patients B, D, and G, regarding his opioid prescribing between March 26, 2017 and November 3, 2020, as detailed above in Paragraphs 5(b)(iv), 5(d)(vi), and 5(g)(ii). Specifically, in prescribing opioids (Percocet, Vicodin, and Tylenol #3) to these patients for acute pain, Dr. Marshall failed to:

a. Consider nonpharmacologic and non-opioid pain treatment prior to prescribing for the patients, as required by 18 VAC 85-21-30(A), and/or clearly document extenuating circumstances for prescribing opioids in quantities exceeding a seven-day supply, as required by 18 VAC 85-21-40(A).

b. Perform a history and physical examination appropriate to the pain complaint, query the Virginia PMP, and conduct an assessment of the patients' history and risk of substance abuse, as required by 18 VAC 85-21-30(B) and 18 VAC 85-21-50.

6. Dr. Marshall violated Virginia Code § 54.1-2915(A)(18) and 18 VAC 85-20-90(B)(1), (3) and (4) of the Board's Regulations in his treatment of Patient B and Patient G with a controlled substance for weight reduction. Specifically, Dr. Marshall initiated treatment of these patients with phentermine (C-IV) without performing and recording an appropriate physical history and examination or prescribing and recording an exercise program, obtaining and/or recording within the first 30 days of prescribing the patients' blood pressure or pulse, or that he ordered/performed and/or reviewed electrocardiogram results for these patients within 30 days of initially prescribing the patients phentermine. Further, Dr. Marshall failed to establish for Patient B or Patient G visit intervals, and failed to assess and/or document the

patients' continued progress toward achieving or maintaining a target weight, as indicated by the following:

a. Regarding Patient B:

i. Dr. Marshall's August 15, 2014 "Telephone Encounter" note indicates that, absent an office visit, he initiated treatment of the patient with #30 phentermine 15mg with four refills, to last through approximately January 15, 2015. On November 24, 2014, Dr. Marshall prescribed an additional #30 phentermine 15mg /30 days with four refills.

ii. On June 18, 2015, per Patient B's telephonic request, Dr. Marshall "refill[ed]" Patient B's phentermine for four months, despite the fact that Dr. Marshall had not seen Patient B for an office visit in over one year (since May 30, 2014).

iii. On May 17, 2017, without a corresponding office visit and despite the fact that Dr. Marshall had not seen Patient B for an office visit in over six months (since November 2016), Patient B filled a prescription written by Dr. Marshall (on May 12, 2017, with two refills) for phentermine.

b. Regarding Patient G:

i. Patient G's PMP report indicates that on August 26, 2017, Dr. Marshall prescribed #30 phentermine 37.5 mg/30 days, absent a corresponding office visit.

ii. Dr. Marshall's medical chart indicates that on April 5, 2018, he prescribed #30 phentermine HCl 37.5mg/30 days, absent a corresponding office visit. Patient G's PMP report shows that he filled this prescription on April 5, 2018, and refilled this prescription on May 16 and June 12, 2018.

c. Dr. Marshall failed to document a medical justification for this prescribing for Patients B and G at any time during the treatment period(s).

7. Dr. Marshall violated Virginia Code § § 54.1-2915.A(3), (13), (16), (17) and (18) and 54.1-3304 in that he dispensed controlled substances to Patient A without being licensed by the Virginia Board of Pharmacy, to include:

a. Between approximately September 2017 and December 2019, unused doses of Fioricet returned by and/or obtained from Patient H and Patient I (as described in Paragraph 5(a)). Specifically:

i. Regarding Patient H, treatment records obtained from Dr. Marshall's practice show that the patient treated with Dr. Marshall (as well as with other providers at Dr. Marshall's practice) between September 2015 and January 2018 for various health conditions/complaints. Patient H's pharmacy records show that on September 24, 2017, the patient filled a prescription written by a nurse practitioner at Dr. Marshall's practice for #20 Fioricet. On an undetermined date, Dr. Marshall provided unused dosages of this medication to Patient A.

ii. Regarding Patient I, treatment records obtained from Dr. Marshall's practice show that on November 29, 2018, the patient presented to a physician at Dr. Marshall's practice, complaining of a recurrent migraine headache. At this visit, the physician prescribed #30 Fioricet. At her next office visit on December 12, 2018, Patient I complained to Dr. Marshall that her continuing migraine headache was not relieved by Fioricet. Dr. Marshall ordered a head CT scan and IM ketorolac (Toradol), which was administered by practice staff. Dr. Marshall did not document Patient I's surrender of unused Fioricet at this office visit. On an undetermined date, Dr. Marshall provided unused dosages of this medication to Patient A.

b. Between approximately 2014 and 2019, viscous lidocaine for use during sexual intercourse/acts (as detailed in Paragraph 2(c)).

c. In or about August 2018, viscous lidocaine to treat mouth sores in Patient A's minor relative (as detailed in Paragraph 4(a)).

d. Further, Dr. Marshall dispensed the viscous lidocaine in the instances described herein in a manner that failed to meet the packaging and labeling requirements in compliance with Virginia Regulations Governing the Board of Pharmacy, 18 VAC 110-20-340 and 18 VAC 110-20-350 (in a test tube labelled "viscous lidocaine").

8. Dr. Marshall violated Virginia Code § § 54.1-2915(A)(3), (13), (16), and (18) and 32.1-127.1:03 and 18 85-20-27(A) of the Board's Regulations, in that he breached patient confidentiality when he dispensed the Fioricet obtained from Patients H and I to Patient A (as detailed in Paragraph 7(a)) in medication bottles with the pharmacy labels attached thereto, indicating personal information such as the patients' names, home addresses, prescribing physicians' names, medication name, date and dosage, pharmacy, etc.

9. Dr. Marshall violated Virginia Code § 54.1-2915(A)(1) and (16) in or about November 2019 in that he documented a false, deceptive and/or fraudulent written evaluation of Patient A's mental and/or physical health. Specifically, Dr. Marshall informed the DHP investigator during his interview that despite the fact that he provided Patient A with evaluative documentation supporting the patient's employment disability claim(s) (as detailed in Paragraph 4(a)), he "was not a fan of her pursuing disability. I tried to be an advocate and support her, but I was concerned if she did get disability, it would prohibit her from being more active…I was glad she was turned down."

10. Dr. Marshall violated Virginia Code § 54.1-2915(A)(1), (3), (10), (16), and (17) between approximately 2017 and 2018, to include the felonies contained in § 18.2-250 and 18.2-258.1 of the Code, in that he knowingly and fraudulently obtained Fioricet, directly or indirectly, from Patients H and I and redistributed the medication to Patient A as detailed in Paragraphs 5(a)(i) and 7(a).

11. Dr. Marshall violated Virginia Code § 54.1-2915(A)(3), (13), and (18) and 18 VAC 85-20-28(B)(2) of the Board's Regulations in or about June 2016 in that he failed to document that he provided Patient C with a reasonable amount of time to obtain the services of another practitioner prior to terminating the practitioner/patient relationship, as detailed above in Paragraph 5(c)(iv).

12. Dr. Marshall is in violation of Virginia Code § 54.1-2915(A)(4) and (13), in that he is unable to practice medicine with reasonable skill and safety and his continued practice represents a danger to his patients and the public, as exhibited by his care of multiple patients and individuals between 2012 and 2020, as detailed above in Paragraphs 1 through 11.

See Confidential Attachment for the names of the patients and individuals referenced above.

Jennifer L. Deschenes, J.D., M.S.
Deputy Executive Director
Virginia Board of Medicine

10/14/2021
Date